STATE OF MICHIGAN

IN THE SUPREME COURT

ON APPEAL FROM THE COURT OF APPEALS
(Jansen, P.J. and Holbrook, Jr., and Griffin, J.J.)

DENISE BRYANT, Personal Representative of the Estate of CATHERINE HUNT, Deceased

Plaintiff-Appellee,

v

OAKPOINTE VILLA NURSING CENTRE, INC., a Michigan corporation,

Defendant-Appellant.
_____/

Supreme Court No. 121723

Court of Appeals No. 228972

Wayne County Circuit Court
No. 98-810412 NO

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Plaintiff-Appellee,

v

OAKPOINTE VILLA NURSING CENTRE, INC., a Michigan corporation

Defendant-Appellant.
_____/

Supreme Court No. 121724

Court of Appeals No. 234992

Wayne County Circuit Court
No. 01-104360 NH

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STATUTES, COURT RULES AND OTHER AUTHORITIES

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STATEMENT REGARDING JURISDICTION

The appeal in docket No. 121723 was before the Court of Appeals on plaintiff's claim of appeal filed within 21 days of the denial of a timely filed motion for rehearing of a final order of dismissal. MCR 7.203(A). The appeal in docket No. 121724 was before the Court of Appeals on leave granted to defendant Oakpointe Villa Nursing Centre, Inc., from an order denying summary disposition. MCR 7.203(B).

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QUESTION PRESENTED FOR REVIEW

WHETHER THIS ACTION AGAINST A SKILLED NURSING FACILITY FOR FAILURE TO RECOGNIZE OR PREVENT A RISK TO A PATIENT OF POSITIONAL ASPHYXIA POSED BY A RESTRAINT DUE TO THE PATIENT'S MEDICAL CONDITION, IS AN ACTION FOR MEDICAL MALPRACTICE TO WHICH THE TORT REFORM REQUIREMENTS APPLY, REQUIRING DISMISSAL OF PLAINTIFF'S ORDINARY NEGLIGENCE ACTION?

A. **Whether This Is A Medical Malpractice Action Pursuant To MCL 600.5838a Because Plaintiff Claims Negligence By Employees Of A Licensed Health Facility--Nurses And/Or CNAs--While "Engaging In Or Otherwise Assisting In Medical Care And Treatment"?**

B. **Whether Alternatively, This Is A Medical Malpractice Action Under Common Law Because The Specific Duty Of Care Owed To The Nursing Home Resident And Claimed To Have Been Breached Exists In The First Instance Only Because Of, And Its Scope Is Defined By, The Professional Health Care Provider--Patient Relationship?**

C. **Whether Alternatively, This Is A Medical Malpractice Action Under Common Law Because It Arises Out Of The Alleged Failure Of A Health Care Facility And Its Employees To Properly Exercise Professional Judgment In Recognizing A Risk Of Positional Asphyxia From A Restraint Due To The Patient's Particular Medical History, And Mental And Physical Condition?**

The trial court held the answer was "Yes" except as to claims of vicarious liability for the CNA.

The Court of Appeals held that the answer was "No."

Defendant Oakpointe Villa Nursing Centre, Inc., submits the answer is "Yes."

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STATEMENT OF FACTS

Defendant Oakpointe Villa Nursing Centre, Inc. appeals by leave granted from the unpublished per curiam decision of the Court of Appeals released on May 21, 2002 (by Judges Kathleen Jansen and Donald Holbrook, with Judge Richard Griffin dissenting in part), reversing orders regarding defendant's motions for summary disposition entered in two Wayne County Circuit Court actions, one alleging ordinary negligence (98-810412 NO), and one alleging medical malpractice (01-104360 NH). (Appx 123a, Court of Appeals opinion, Appx 80a, 117a, orders granting and denying summary disposition). Both actions arose out of identical facts--the death of Catherine Hunt at Oakpointe Villa Nursing Centre, Inc., a skilled nursing facility, due to positional asphyxia. The Court of Appeals majority held that plaintiff's claim properly sounded only in ordinary negligence; all members of the Court further held that any claim for medical malpractice was barred by the statute of limitations.

At issue in this appeal is whether, based on the allegations in plaintiff's first amended complaint in the first lawsuit, and the discovery conducted in that suit of various witnesses, including plaintiff's expert, Dr. Steven Miles, this is an action "alleging medical malpractice" to which various tort reform requirements apply (these include the presuit notice requirement, MCL 600.2912a, the affidavit of merit requirement, MCL 600.2912d, and the cap on noneconomic damages, MCL 600.1483; all relevant statutes attached at Appx 143a, relevant statutes). The facts relevant to this determination and the procedural history of the two lawsuits is set forth below.

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Underlying Facts

Catherine Hunt had been placed in Oak Pointe Villa Nursing Centre, a skilled nursing facility, by her niece, Denise Bryant, in April 1996 because Mrs. Hunt needed 24-hour care (Appx 28a, Bryant dep, pp 27-28). At the time of the incident at issue, March 2, 1997, Mrs. Hunt was a 66-year-old woman who had suffered multiple strokes and had a diagnosis upon admission of dementia. Mrs. Hunt was in need of total assistance with transfers, locomotion, dressing, eating, toileting and bathing, and suffered from diffuse weakness as well as impaired balance and judgment (Appx 59a-60a, deposition of plaintiff's expert, Dr. Miles, pp 108, 110).

On the morning of March 2, 1997, Mrs. Hunt was found with her neck caught between the raised bed rails and the mattress of her bed in the skilled nursing facility. Death was attributed to asphyxiation (Appx 30a, Olds dep, pp 41-44, Appx 49a, 50a, 50a-1 Miles dep, pp 56-57, 67).

Plaintiff's expert witness, Dr. Miles, indicated that Mrs. Hunt probably did not simply accidentally roll off the mattress into the bed rails when she became entangled. Rather, Dr. Miles testified that Mrs. Hunt, when she became caught or entangled, was probably trying to climb out of and exit the bed, due to her impulsive sliding behavior (Appx 54a, Miles dep, pp 87-88):

> A In most instances, the way that these deaths appear to occur is a patient who has a history of impulsive sliding behavior and poor judgment and physical frailty starts to exit a chair or a bed in a manner that they've done unsafely before and has not been addressed by the nursing staff and that, on that occasion, it results in an asphyxiation. And the death of Mrs. Hunt fits that profile to a tee.
>
> Q How so?
>
> A She was frail, she required assistance with her activities of daily living, her judgment was impaired, she had a long history of

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> sliding out of position. It appears that she had a history of sliding out of position with regard to the bed as well as in a recent--recently, as judged by testimony to a police investigator in one of the nursing depositions.
>
> And, in addition to that, the medical record reflects a history of sliding with regard to chairs. There are huge areas of medical records, which seem to not--do not have nurses' notes for large numbers of days, which is very unusual. And then she proceeded to slide out of bed and have an asphyxiation death. There was a failure to individualize her treatment plan. [Appx 52a, Miles dep, pp 74-75.]

Plaintiff claims that defendant's staff had or should have had prior notice of the potential for entanglement in the bed rails and was negligent in failing to take steps to eliminate the risk of positional asphyxia. One basis for this assertion was testimony that Certified Nurse Assistants ("CNA" or "CENA") Valerie Roundtree and Monee Olds, on the day before the accident, March 1, 1997, had observed the patient, Mrs. Hunt, tangled in her bed sheets (not the bed rails) (Appx 69a-72a, Roundtree dep, pp 18-21).

There is contradictory testimony as to whether the CNAs then reported to the charge nurse their observation of Mrs. Hunt's entanglement in her bedcovers. The charge nurse on duty at the time of the CNAs' observation, Kafi Wilson, L.P.N., denied that anyone had reported this finding. The CNAs, however, claimed that Valerie Roundtree had reported the incident to the charge nurse (Appx 75a-79a, Wilson dep, pp 8, 27-30, Appx 69a-72a, Roundtree dep, pp 18-21). Ms. Roundtree was fired after this incident, but reinstated after an arbitrator found as a factual matter that the CNA had expressed her concerns to the charge nurse, but that the charge nurse had elected not to take action.

As a result of this incident and in order to prevent it from happening again, Oakpointe Villa Nursing Centre took steps to identify residents who could have been

at risk of sliding between the side rails and mattress and added mattress pads to attempt to close the gap. There was also in-service education for nursing facility staff related to this problem (Appx 79(1)a, dep of Oakpointe administrator, Myrick, p 17).

Procedural Background--"Ordinary Negligence" Lawsuit

In plaintiff's original complaint filed on April 3, 1998, plaintiff alleged negligence in failing to properly supervise plaintiff's decedent and failing to maintain safe and appropriate equipment upon the premises (Appx 5a, complaint, ¶ 7). Defendant Oak Pointe Villa Nursing Centre moved for summary disposition pursuant to MCR 2.116(C)(1), (4) and (8). Defendant submitted that plaintiff's claim was in actuality a claim for medical malpractice to which the tort reform requirements of presuit notice and an affidavit of merit, MCL 600.2912(b)(1) and MCL 600.2912(d), applied.

At a hearing on July 17, 1998, Judge Pamela R. Harwood, after reviewing the "rather short complaint", concluded that it sounded to her to be a claim of ordinary negligence rather than malpractice "at this point" (Appx 14a-15a, Tr 7/17/98, pp 6-8, emphasis added). Accordingly, the court denied the motion, and indicated that plaintiff was not required to comply with tort reform requirements (Appx 16a, Tr 7/17/98, p 8, Appx 18a, August 3, 1998 order).

On July 26, 1999, plaintiff filed a first amended complaint (Appx 20a). Plaintiff alleged, among other things, that Oak Pointe Villa Nursing Centre owed a duty to plaintiff's decedent to assure that CNAs employed by Oakpointe Villa were "properly trained regarding dangers posed to nursing home residents by bed rails and positional asphyxia." Plaintiff alleged that the facility was guilty of "negligently and recklessly failing to train CNAs to assess the risk of positional asphyxia by plaintiff's

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decedent . . . " (Appx 21a, 22a, first amended complaint, ¶¶ 5, 10(b)). Plaintiff further alleged negligence by Oakpointe in "failing to assure that plaintiff's decedent was provided with an accident-free environment", "failing to assess the risk of positional asphyxia by plaintiff's decedent", and failing to inspect the beds and mattresses "to assure that the risk of positional asphyxia did not exist." (Appx 22a, first amended complaint, ¶1(1)(a)-(e).)

Thereafter, discovery, specifically the deposition testimony of plaintiff's expert witness, Dr. Miles, established what plaintiff claimed to be an applicable professional standard of practice by nursing homes with regard to identification of the risk of positional asphyxia due to bed rails. (Appx 45a-60a, dep of Dr. Miles, discussed further in the argument below.) Based on such information in discovery and the new allegations in the amended complaint, defendant Oakpointe Villa Nursing Center brought a motion to dismiss on October 15, 1999. Defendant submitted that it had become clear that plaintiff's claim was in fact one for medical malpractice and that dismissal without prejudice was mandated for plaintiff's failure to comply with the statutory requirements applicable to medical malpractice actions. At the request of Judge Harwood at a hearing held on November 12, 1999, full depositions of witnesses were submitted by the parties to the trial court supplementally on November 19, 1999, "regarding precisely what a CENA or LPN at Oakpointe Villa should have done" to protect Catherine Hunt from the risk of strangulation (plaintiff's supplemental brief, p 1).

Thereafter, Judge Harwood recused herself and the matter was reassigned to Judge John A. Murphy, who heard argument on the motion to dismiss on April 13, 2000. In an opinion and order of June 16, 2000 (Appx 80a-94a), Judge Murphy

granted defendant's motion and dismissed the case without prejudice to plaintiff's refiling the same as a malpractice action upon compliance with the tort reform requirements. The court concluded that discovery had established that the allegations here involved the exercise of professional judgment and, therefore, were properly characterized as malpractice:

> All the excerpts [of testimony] indicate the same thing: that when the employees wished to adjust the quantity or type of bedding a patient was to receive they had to consult with the "restorative nurse"--in other words, they had to obtain "professional judgment" see e.g., Exh. E at 33-34, Motion to Dismiss Plaintiff's Complaint and First Amended Complaint (employee stating that a doctor's order was needed in order to use a bed rail cover or "wedge" on patient's bedding), Exhs. F-H (same); see also, Defendant's Exh. I (testimony by physician that "professional judgment" needed to restrain patient). This last piece of testimony--from the physician--is from an expert retained by Plaintiff. [Appx 83a, Opinion, p 4.]

The trial court noted that the allegations here were similar to those in two cases in which the Court of Appeals had required expert testimony, Starr v Providence Hospital, 109 Mich App 762 (1981), and Waatti v Marquette General Hospital, Inc, 122 Mich App 44 (1982). The court concluded that the allegations against the facility and its staff were claims of medical malpractice (Appx 89a-90a, opinion pp 10-11).

Judge Murphy in his opinion, went on, however, to conclude that if the complaint had alleged that the nursing home was vicariously liable for negligence by the CNAs, this would have involved ordinary negligence rather than medical malpractice. The trial court further concluded, however, that such claims had not been alleged (Appx 91a-94a, Opinion). The court thereafter denied plaintiff's motion for rehearing (Appx 95a-102a, Opinion).

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Plaintiff filed an appeal to the Court of Appeals from the dismissal without prejudice of her complaint (docket no 228972). Oakpointe Villa Nursing Centre, Inc., filed a cross-appeal solely in order to ensure its ability to argue that all of plaintiff's claims, including those which could be alleged against the CNA, would involve a claim for medical malpractice subject to the statutory tort reform requirements.

Procedural Background--Malpractice Lawsuit

Following the dismissal of the ordinary negligence action, and having mailed a notice of intent under MCL 600.2912b, plaintiff on February 7, 2001, filed another lawsuit expressly alleging medical malpractice. That complaint was supported by an affidavit of merit by a registered nurse, citing MCL 600.2912d (Appx 103a-116a, complaint and affidavit of merit).

Defendant Oakpointe Villa Nursing Centre, Inc. moved for summary disposition based on the medical malpractice statute of limitations. Plaintiff conceded in response that the medical malpractice statute of limitations would bar that suit unless the statute was tolled during the pendency of the first lawsuit alleging ordinary negligence. (According to plaintiff, the statute of limitations would have expired at the latest on January 20, 2000, two years from issuance of the letters of authority, as allowed by MCL 600.5852, the wrongful death savings statute.)

Judge Murphy denied defendant's motion for summary disposition of the second suit expressly alleging medical malpractice. The court held that "judicial tolling" extended the malpractice statute of limitations during the pendency of the ordinary negligence suit (Appx 117a, June 5, 2001, opinion and order). Oakpointe Villa Nursing Centre, Inc., appealed to the Court of Appeals by leave granted from that order (docket no 121724).

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Court of Appeals Decision

The two appeals, the first by plaintiff from the dismissal of the negligence action, and the second by defendant from the trial court's decision refusing to dismiss the malpractice action, were consolidated by the Court of Appeals. In an unpublished per curiam decision released on May 21, 2002 (by Judges Kathleen Jansen and Donald Holbrook, with Judge Richard Griffin dissenting in part), the Court of Appeals reversed both the order granting summary disposition in the "ordinary negligence" lawsuit, and the order denying summary disposition in the malpractice lawsuit (Appx 123a, opinion).

The Court of Appeals majority held that the underlying claim arising out of an alleged breach of duty in failing to properly supervise and care for a nursing home patient in light of that patient's particular mental and physical condition is a claim for ordinary negligence, rather than one for medical malpractice. The majority opinion, in reliance on decisions from Illinois and Georgia, held that a claim such as this one sounds in ordinary negligence because it merely involves "custodial shelter care." Thus, the Court of Appeals majority held that Wayne County Circuit Judge John Murphy improperly dismissed plaintiff's first lawsuit on the ground that plaintiff was required to but had failed to comply with the tort reform requirements applicable to medical malpractice actions (Wayne County Docket No 98-810412-NO, Court of Appeals Docket No 228972). (Appx 123a, opinion.)

Judge Griffin dissented on the basis that the claim was one of malpractice because it involved questions of medical or professional judgment--"whether bed rails were appropriate or necessary for Hunt", and "whether defendant failed to properly

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supervise Hunt, failed to provide the appropriate attendant care, or failed to properly train its CENAs. . . ". (Appx 127a, dissent.)

The Court of Appeals (both majority and dissent) did unanimously hold that plaintiff's second lawsuit, alleging that the same failure to properly supervise a nursing home patient was medical malpractice, was barred by the statute of limitations. The Court held the malpractice statute of limitations was not tolled by the pendency of the ordinary negligence action (Appx 127a, opinion). With this holding defendant, of course, does not disagree. Plaintiff has never filed a cross appeal from this determination.

Defendant Oakpointe Villa Nursing Centre, Inc., now seeks a determination by this Court that plaintiff's claim in the "ordinary negligence lawsuit" (Wayne County Circuit Court Docket No 98-8810412 NO) was in fact in its entirety an action for malpractice and not ordinary negligence, such that it was properly dismissed by the Wayne County Circuit Court.

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SUMMARY OF ARGUMENT

Essentially three tests have been employed by Michigan courts in various contexts for determining whether an action will be subject to the procedural requirements and limitations applicable to a medical malpractice action. The most restrictive analysis--whether the care at issue involves "professional judgment"--while sufficient to establish a claim is one for malpractice--should not end the inquiry. Defendant Oakpointe Villa Nursing Centre, Inc., submits that an action is one for malpractice, if it satisfies any one of the three primary tests developed through Legislature and common law.

Defendant submits that in the context of a claim against an employee of a licensed health facility, such as Oakpointe Villa Nursing Centre, this Court should endorse the test based on the Legislature's effective definition of medical malpractice in MCL 600.5838a which was applied by the Court in Regalski v Cardiology Associates, PC, 459 Mich 881; 587 NW2d 502 (1998): an action is one for medical malpractice if it turns on acts or omissions by a licensed health care professional, or any employee or agent of a licensed health facility, while "engaging in or otherwise assisting in medical care and treatment." Under this analysis, the claims here are for malpractice because they are asserted against a licensed health care facility based on negligence of nurses and/or unlicensed employees, CNAs, while engaging in or otherwise assisting in medical care--specifically the administration and monitoring of patient restraints.

Alternatively, this claim is one for medical malpractice because it meets a second test developed under common law--the specific duty of care owed to the nursing home resident and claimed to have been breached exists in the first instance

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only because of, and its scope is defined by, the professional health care provider--patient relationship. The relationship of premises owner to invitee, which would give rise to a claim for ordinary negligence, is not implicated and would not support liability here.

Finally, even if it were not only sufficient but necessary to meet the "professional judgment" test, discovery and the allegations in plaintiff's amended complaint establish that professional judgment was clearly implicated here.

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ARGUMENT

THIS ACTION AGAINST A SKILLED NURSING FACILITY FOR FAILURE TO RECOGNIZE OR PREVENT A RISK TO A PATIENT OF POSITIONAL ASPHYXIA POSED BY A RESTRAINT DUE TO THE PATIENT'S MEDICAL CONDITION, IS AN ACTION FOR MEDICAL MALPRACTICE TO WHICH THE TORT REFORM REQUIREMENTS APPLY, REQUIRING DISMISSAL OF PLAINTIFF'S ORDINARY NEGLIGENCE ACTION.

This is an action "alleging medical malpractice" to which the tort reform legislation applies, notwithstanding plaintiff's efforts to characterize it as an action for ordinary negligence. For purposes of the applicability of the medical malpractice tort reform requirements in 1986 PA 178 and 1993 PA 78, a plaintiff's election to characterize a claim as one for ordinary negligence rather than malpractice is irrelevant. Dorris v Detroit Osteopathic Hospital, 460 Mich 226; 594 NW2d 445 (1999). "'A complaint cannot avoid application of the procedural requirements of a malpractice action by couching its cause of action in terms of ordinary negligence.'" Id.

Plaintiff's failure to comply with the tort reform requirements requires summary disposition. The decision whether to grant summary disposition is reviewed de novo. Turner v Mercy Hospital, 210 Mich App 345; 533 NW2d 365 (1995).

A. Medical Malpractice Versus "Ordinary Negligence": An Historical Overview.

Prior to 1975, medical malpractice was defined at common law such that only physicians could commit "malpractice." Kambas v St Joseph's Mercy Hospital, 389 Mich 249; 205 NW2d 431 (1984). Thus, only physicians were subject to the shorter, two-year period of limitations under former MCL 600.5838, which applied to claims based on the malpractice of a member of a "state licensed profession." Kambas v St Joseph's Mercy Hospital, supra (holding that hospitals were not subject to the

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medical malpractice statute of limitations for negligent nursing care; the pre-1975 version of MCL 600.5838 is quoted in Adkins v Annapolis Hospital, 420 Mich 87, 91 n 8; 360 NW2d 150 (1984).)

In 1975, two years after Kambas, MCL 600.5838 was amended to define the accrual date of, and to apply to claims of malpractice by a member of a state licensed profession as well as, inter alia, to claims of malpractice by a hospital or a "licensed health care facility, employee or agent of a hospital or licensed health care facility who is engaging in or otherwise assisting in medical care and treatment." In Adkins v Annapolis Hospital, 420 Mich 87, 93-95; 360 NW2d 150 (1984), the Court held that although this amendment (quoted in full in Adkins, at page 93), was a limitations accrual provision, it was effective to modify the common law definition of malpractice. The Court held that this amendment expanded the class of individuals who may be sued for malpractice to those listed in the statute.[1] See also Cox v Board of Hospital Managers for the City of Flint, 467 Mich 1; 651 NW2d 356 (2002), noting that by this 1975 amendment the Legislature created actions for malpractice which had not existed previously.

In determining whether an action is one for medical malpractice, Michigan courts have applied essentially three analyses or tests. These have variously been applied for three different purposes--for determining whether expert testimony is required to establish a prima facie case, whether the claim is one subject to the two-

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[1] In 1986, as part of the first round of tort reform legislation, 1986 PA 178, the medical malpractice provisions of MCL 600.5838 were moved to MCL 600.5838a.

year malpractice statute of limitations, or whether the claim is subject to tort reform requirements applicable to medical malpractice actions.

Courts had applied the "professional judgment" test in actions against physicians for poor medical care to determine whether expert testimony regarding the standard of practice was required to establish a prima facie case. See Lince v Monson, 363 Mich 135; 108 NW2d 845 (1961) (physician), Fogel v Gold, 2 Mich App 99; 138 NW2d 503 (1965) (nurse's aid), Gold v Sinai Hospital, 5 Mich App 368; 146 NW2d 723 (1966) (nurse). In Adkins, 95, n 10, the Court stated in dicta that some hospital errors in hospital care may be ordinary negligence rather than malpractice.

In Dorris v Detroit Osteopathic Hospital, supra, this Court recently referenced both the professional judgment and source of duty tests in the context of determining applicability of statutory tort reform requirements. In Dorris, the plaintiff alleged that she was injured during an assault and battery by a fellow patient at the hospital. The plaintiff asserted that her claim that the hospital was negligent in failing to properly supervise and monitor patients was one for ordinary negligence and thus not subject to the notice of intent and affidavit of merit requirements applicable to medical malpractice actions (as set forth in MCL 600.2912b and MCL 600.2912d).

The Court in Dorris stated that "whether a claim will be held to the standards of proof and procedural requirements of a medical malpractice claim as opposed to an ordinary negligence claim depends on whether the facts allegedly raise issues that are within the common knowledge of the jury or, alternatively, raise questions involving medical judgment."

Holding that the claims before it were for medical malpractice and subject to the tort reform requirements, the Court in Dorris also quoted with approval from

Bronson v Sisters of Mercy Health Corporation, 175 Mich App 647; 438 NW2d 276 (1989), the second common law test: "'the key to a medical malpractice action is whether it is alleged that the negligence occurred within the course of a professional relationship.'" In Bronson the Court of Appeals had held that a claim against a hospital for negligent staffing or supervision of staff is a claim for malpractice for purposes of determining the applicability of the statute of limitations.

In Regalski v Cardiology Associates, PC, 459 Mich 881; 587 NW2d 502 (1998), this Court employed a third test, based on the language used by the Legislature in extending the medical malpractice statute of limitations to actions of any agent or employee of a licensed health care facility "engaged in or otherwise assisting in medical care." MCL 600.5838, now MCL 600.5838a (Appx 157a).

Under each or any of these tests, this is an action for medical malpractice.

B. This Is A Medical Malpractice Action Pursuant To MCL 600.5838a Because Plaintiff Claims Negligence By Employees Of A Licensed Health Facility--Nurses And/Or CNAs--While "Engaging In Or Otherwise Assisting In Medical Care And Treatment."

Involvement of "professional judgment" in the provision of health services is sufficient to establish an action to be one for medical malpractice under one traditional common law test. Dorris, supra. However, defendant submits that the Legislature's view of what constitutes "medical malpractice" for purposes of the applicability of legislation governing actions alleging medical malpractice is broader. The exercise of "professional judgment," while sufficient, is not necessary to establish an action to be one for medical malpractice.

In light of MCL 600.5838a, a claim is one for malpractice if it is based on the conduct of any employee or agent of a licensed health facility who is engaged in or

"otherwise assisting in medical care and treatment," regardless of whether the employee is actually engaged in medical care, or exercising professional judgment.

(1) MCL 600.5838a has extended the definition of medical malpractice to include conduct of any employee engaging in or otherwise assisting in medical care, regardless of the direct involvement of professional judgment.

As held by the Court in Adkins v Annapolis Hospital, supra, and acknowledged in Cox v Board of Hospital Managers for the City of Flint, supra, the effect of MCL 600.5838, now MCL 600.5838a, although an accrual provision, was to expand the definition of medical malpractice beyond that recognized at common law. MCL 600.5838a provides, in relevant part:

> For purposes of this act, a claim based on the medical malpractice of a person or entity who is or who holds himself or herself out to be a licensed health care professional, licensed health facility or agency, or an employee or agent of a licensed health facility or agency who is engaging in or otherwise assisting in medical care and treatment, whether or not the licensed health care professional, licensed health facility or agency, or their employee or agent is engaged in the practice of the health profession in a sole proprietorship, partnership, professional corporation, or other business entity, accrues at the time of the act or omission that is the basis for the claim of medical malpractice, regardless of the time the plaintiff discovers or otherwise has knowledge of the claim. As used in this subsection:
>
> (a) "Licensed health facility or agency" means a health facility or agency licensed under article 17 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.20101 to 333.22260 of the Michigan Compiled Laws.
>
> (b) "Licensed health care professional" means an individual licensed or registered under article 15 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16101 to 333.18838 of the Michigan Compiled Laws, and engaged in the practice of his or her health profession in a sole proprietorship, partnership, professional corporation, or other business entity. However, licensed health care professional does not include a sanitarian or a veterinarian. [Appx 157a.]

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Thus, MCL 600.5838a has effectively extended the definition of medical malpractice to include the conduct not only of licensed health care professionals and licensed health facilities exercising professional medical judgment, but also to include the conduct of "an employee or agent of a licensed health care facility or agency who is engaging in or otherwise assisting in medical care and treatment." Accordingly, an action is one alleging medical malpractice, regardless of whether the immediate cause of the injury involves the exercise of professional judgment, if it involves an employee "otherwise assisting" in medical care and treatment. This conclusion is supported by this Court's decision in Regalski, supra.

In Regalski, the plaintiff had asserted a claim against a medical professional corporation for injuries sustained by plaintiff's decedent when, preparatory to a medical examination, she was lifted by defendant's staff from a wheelchair to an examining table. The Court of Appeals in an unpublished opinion had held that this was a claim for ordinary negligence rather than malpractice for purposes of application of the statute of limitations. Regalski v Cardiology Associates, PC, unpublished memorandum opinion of the Court of Appeals, decided 9/19/97 (Docket No 195425) (Appx 135a). The Court of Appeals so concluded because "neither medical expertise nor medical training or supervision" was required for a technician employed by a medical facility to lift a patient from a wheelchair to a bed (Appx 136a).

The Supreme Court in Regalski, however, peremptorily reversed. The Court unanimously held that a claim of negligence by an unlicensed hospital technician in assisting a patient to move from a wheelchair onto a table was medical malpractice, rather than ordinary negligence. This was because the actor was (1) an employee of

a licensed health care provider, (2) who was engaging in or otherwise assisting in medical care and treatment. The Court reasoned:

> Since the passage of 1975 PA 142, the Legislature has extended the shortened two-year period [of limitations] to claims based on the medical malpractice of "an employee or agent of a licensed health facility or agency who is engaging in or otherwise assisting in medical care and treatment," as well as that of a licensed health care professional. See MCL 600.5838a(1); MSA 27A.5838(1)(1).
>
> In the present action, the plaintiff has alleged Elizabeth Regalski was injured because the defendant's technician was negligent in assisting the patient's movement out of a wheelchair and onto the examination table where the technician then performed the cardiac test for which the defendant had been consulted. Like the trial judge, we are persuaded that the technician was "engaging in or otherwise assisting in medical care and treatment" in the performance of the act that is the basis of this lawsuit and the case, therefore, is governed by the two-year period of limitations applicable to medical malpractice claims. [Regalski, 881.]

Defendant submits that this should again be endorsed by this Court as a correct statement of the law, and a viable test for determining the applicability of statutory procedural requirements for malpractice actions. A claim is one for medical malpractice, regardless of whether it will ultimately turn on the exercise of professional medical judgment or merely involves the "ordinary negligence" of a CNA or other licensed or unlicensed health professional, if it involves engaging in or otherwise assisting in medical care. This accurately reflects the Legislature's intent.

(2) The claims here are for malpractice because they are asserted against a licensed health care facility based on negligence of nurses and/or unlicensed employees, CNAs, engaging in or otherwise assisting in medical care--specifically the administration and monitoring of patient restraints.

Oak Pointe Villa Nursing Centre, as a skilled nursing facility, was a "licensed health facility," providing physician- and nurse-directed medical care, in which CNAs assisted, to plaintiff's decedent with respect to the conduct at issue here--the

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administration and monitoring of patient restraints. Nursing homes in Michigan are governed by Part 217 of Article 17 of the Michigan Public Health Code, MCL 333.21701-MCL 333.21799e. In order to operate as a nursing home, a facility must be a licensed health facility under Article 17 of the Public Health Code. MCL 333.21711. A nursing home is statutorily defined as a "nursing care facility . . . which provides organized nursing care and medical treatment" to individuals suffering illness or infirmity. MCL 333.20109(1) (Appx 143a).

MCL 333.21715(1) (Appx 149a) requires that a nursing home provide a program of planned and continuing medical care under the charge of physicians. MCL 333.21715(2) provides that the "nursing care" and "medical care" so provided in a nursing home "shall consist of services given to individuals who are subject to prolonged suffering from illness or injury or who are recovering from illness or injury":

> (1) A nursing home shall provide:
>
> * * *
>
> (b) A program of planned and continuing medical care under the charge of physicians.
>
> (2) Nursing care and medical care shall consist of services given to individuals who are subject to prolonged suffering from illness or injury or who are recovering from illness or injury. The services shall be within the ability of the home to provide and shall include the functions of medical care such as diagnosis and treatment of an illness; nursing care via assessment, planning, and implementation; evaluation of a patient's health care needs; and the carrying out of required treatment prescribed by a physician. [MCL 333.21715(2) Appx 149a.]

CNAs, or Certified Nurse's Aides (also referred to as "CENAs"), such as Monee Olds and Valerie Roundtree here, assist in the provision of medical care within nursing facilities. CNAs are required to be registered with the state pursuant to state and federal law. See MCL 333.21795 (Appx 153a); Michigan Administrative

Code 325.20703; 42 CFR 483.150-483.156. 42 CFR 483.156 requires each state to establish and maintain a registry of nurse's aides. The requirements for training and registration of CNAs are set forth in the Federal Medicare/Medicaid regulations, 42 CFR 483.150-483.152.

In the words of plaintiff's own expert, Dr. Miles, "nursing assistants are hired by the facility to complete the facility's mission and responsibility to provide professional care for vulnerable individuals." (Appx 57a, Dr. Miles dep, p 100.)

Further, under the Michigan Public Health Code, evaluating the need for and determining the type of appropriate restraints, including bed rails and wedges, to be applied to a resident of a skilled nursing facility is defined as the provision of medical care. MCL 333.20201(2)(l) (Appx 144a) provides that a patient or resident "is entitled to be free . . . from physical and chemical restraints, except those restraints authorized in writing by the attending physician for a specified and limited time or as are necessitated by emergency to protect the patient or resident from injury to self or others . . . ." The record below established that virtually any adaptation to the bed of a resident related to the bed rails is considered a restraint, for which a physician's order is required. This includes bed rails, a bed rail cover, or a wedge to be placed between the rail and bed (Appx 29(1)a, Davis dep, pp 33-35, Appx 34a, Drew Dep, pp 77-80, Appx 35a, Hollis' dep, p 87, Appx 37a, Dreyfuss dep, p 9). Grace Andrews, R.N., the state investigator who initially investigated the incident, testified that whether a bumper pad should be used with a particular patient in a nursing home was a professional judgment (Appx 42a, Andrews dep, p 119, exhibit to supplemental brief in support of motion for summary disposition).

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MCL 333.21734 (Appx 151a) confirms that bed rails are a form of restraint requiring a physician order. Bed rails are permitted only when warranted by a patient's particular medical symptoms: bed rails may not be used without a "written order from the resident's attending physician that contains statements and determinations regarding medical symptoms and that specifies the circumstances under which bed rails are to be used". (Id.)

Thus, the use of bed rails upon the determination that they are required by a resident's symptoms pursuant to physician order plainly is an aspect of engaging in "medical care and treatment." Plaintiff's factual claims of negligence here clearly all challenge the conduct of employees in either engaging in, or assisting in the provision of, such medical care. Plaintiff claims the nursing home staff--CNAs and nurses--identified but failed to respond appropriately to the risk of asphyxiation posed by the bed rail configuration with the mattress to this patient in light of her particular medical/psychiatric infirmities. This is a claim of "medical malpractice" as that term has effectively been defined by the Legislature through MCL 600.5838a.

(3) Principles of statutory construction and the policy underlying the tort reform acts are consistent with application of those requirements to a claim against a health care facility regardless of whether the exercise of professional judgment is directly involved.

The analysis in Regalski applies as well to the definition of "medical malpractice" throughout the tort reform provisions in 1993 PA 78, as a matter of both logic and statutory construction. The tort reform requirements at issue in this lawsuit--the cap on noneconomic damages, MCL 600.1483, the presuit notice requirement, MCL 600.2912b, the affidavit of merit requirement, MCL 600.2912d, and the medical malpractice statute of limitations, MCL 600.5838a, were all enacted or amended to

the version applicable to this matter as part of the second round of tort reform, 1993 PA 78 (a different version of the cap statute, MCL 600.1483, and of the medical malpractice statute of limitations, MCL 600.5838a, had been enacted as part of the first round of tort reform, 1986 PA 178) (current statutes at Appx 154a-156a).

The Legislature's definition of "medical malpractice" in connection with the statute of limitations applies as well to determine whether this claim is one of "medical malpractice" for purposes of whether the other tort reform provisions in 1993 PA 78 will apply. The phrase "medical malpractice" used in all of these statutes must be read in pari materia:

> When construing these statutory sections, we apply the accepted rule that the terms of statutory provisions having a common purpose should be read in pari materia. Jennings v Southwood, 446 Mich 125, 136; 521 NW2d 230 (1994). The object of this rule is to give effect to the legislative purpose as found in statutes on a particular subject. *Id.* at 137. Conflicting provisions of a statute must be read together to produce an harmonious whole and to reconcile any inconsistencies wherever possible. Gross v General Motors Corp, 448 Mich 147, 164; 528 NW2d 707 (1995); Weems v Chrysler Corp, 448 Mich 679, 699-700; 533 NW2d 287 (1995). [World Book, Inc v Dep't of Treasury, 459 Mich 403 1999).]

A consistent definition of "medical malpractice" must be presumed to have been intended by the Legislature.

Plaintiff's assertion below that MCL 600.2912 defines an action for medical malpractice and limits such an action to state licensed professionals (Court of Appeals brief, pp 12-13), is without merit. In Kambas v St Joseph's Mercy Hospital of Detroit, supra, and again in Adkins v Annapolis Hospital, supra, the Court held that section 2912 merely extended the malpractice cause of action to pseudo-professionals serving in professions that were already subject to malpractice actions.

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Given the overriding purpose of the tort reform legislation, it would make no sense that the application of those provisions to claims against health care providers for injuries arising out of the rendition of medical care and treatment would depend solely on whether the health care provider's error can be characterized as involving professional judgment, or a matter within the understanding of the ordinary layperson. The purpose of the tort reform legislation was to reduce the burden placed on Michigan's health care providers by frivolous lawsuits and outrageous noneconomic damage awards, in order to assure the continued affordability and availability of health care. See Sills v Oakland General Hospital, 220 Mich App 303; 559 NW2d 348 (1996) (upholding constitutionality of the six-year cap), McDougall v Schanz, 461 Mich 15; 597 NW2d 148 (1999), quoting McDougall v Schanz, 218 Mich App 501; 554 NW2d 56 (1996) (dissent by Judge, now Justice, Taylor).

> This public act [1993 PA 78] was enacted for the general purpose of addressing the problems of, and widespread dissatisfaction with, Michigan's medical liability system, specifically, the availability and affordability of medical care in the face of spiraling costs. Senate Bill Analysis, SB 270, August 11, 1993; House Legislative Analysis, HB 4403-4406, March 22, 1993. As indicated previously, § 2912b(1) was enacted for the purpose of promoting settlement without the need for formal litigation and reducing the cost of medical malpractice litigation while still providing compensation for meritorious medical malpractice claims that might otherwise be precluded from recovery because of litigation costs. "The state unquestionably has a legitimate interest in securing adequate and affordable health care for its residents." Bissell v Kommareddi, 202 Mich App 578, 580-581; 509 NW2d 542 (1993) [Neal v Oakwood, 226 Mich App 701; 575 NW2d 68 (1997).]

Thus, the problems addressed by the Legislature through the tort reform statutes are those affecting health care providers and facilities in the provision of medical care, irrespective of whether professional judgment is involved. While certainly those cases involving professional judgment are within the scope of the statutes (as the Court found in Dorris), a broader analysis must also be considered

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where the specific conduct at issue does not or may not involve "professional judgment."

C. Alternatively, This Is A Medical Malpractice Action Under Common Law Because The Specific Duty Of Care Owed To The Nursing Home Resident And Claimed To Have Been Breached Exists In The First Instance Only Because Of, And Its Scope Is Defined By, The Professional Health Care Provider--Patient Relationship.

Even if the Court were to decline to apply the 600.5838a definition, or to find that this matter did not arise out of the conduct of nursing home employees "otherwise assisting in medical care," this nonetheless is an action for malpractice under the common law source of duty/professional relationship test. Plaintiff's decedent was in a skilled nursing facility; only because of its relationship to Mrs. Hunt as a skilled nursing facility did defendant have an obligation to take extra steps to protect Mrs. Hunt from the risk of positional asphyxiation. This duty existed solely because of plaintiff's decedent's physical and mental condition, which created the need for and duty to provide skilled nursing care, under the direction of a physician, and was prerequisite to her admission to this facility.

"'The key to a medical malpractice action is whether it is alleged that the negligence occurred within the course of a professional relationship.'" Dorris v Detroit Osteopathic Hospital Corp, 460 Mich 26; 594 NW2d 445 (1999), quoting Bronson v Sisters of Mercy Health Corp, supra, Simmons v Apex Drug Stores, 201 Mich App 250; 506 NW2d 562 (1993). "The term 'malpractice' denotes a breach of the duty owed by one in rendering professional services to a person who has contracted for such services." Rogers v Horvath, 65 Mich App 644, 646-647; 237 NW2d 595 (1975). In the analogous context of the attorney-client relationship, the Court in Bernard v Dilly, 134 Mich App 375; 350 NW2d 887 (1984), held that the

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source of the duty--a professional relationship--was determinative of whether the claim was for legal malpractice or ordinary negligence, reasoning:

> Plaintiff also claimed that defendant Dilly was liable to her based on a general theory of negligence. This claim was properly rejected by the trial court. To establish a tort, one must first establish a duty to the claimant imposed on the alleged tortfeasor. The only claim of duty contained in plaintiff's first amended complaint arises out of the attorney-client relationship between plaintiff and defendant Dilly. Where the alleged duty arises out of such a relationship, the tort claim is one for malpractice and malpractice only. [Bernard, 378-379.]

The source of the duty owed by defendant here to plaintiff, which is claimed to have been breached, is the fact that it is a licensed health care facility, and that its relationship to plaintiff is that of patient/health care provider providing medical care. Regardless of whether the particular or immediate error causing the injury involved the exercise of (or failure to exercise) "professional judgment", the duty not to commit that error in the first place arose only because of the unique nature of the professional, health care provider-patient relationship between this health care provider defendant and the plaintiff. This critical fact renders this a claim for malpractice.

In Smith v Harper-Grace Hospital, unpublished memorandum opinion of the Court of Appeals, decided 3/14/97 (docket no 181321) (Appx 141a), the Court of Appeals held that regardless of whether professional judgment was involved, the claim was one for malpractice because it arose out of a professional medical relationship. There, the Court rejected plaintiff's argument that the three-year statute of limitations for ordinary negligence applied to claims that the defendant health care provider incorrectly placed information in the patient's medical chart. The Court reasoned:

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> Although couched in terms of ordinary negligence, plaintiff's claim arose within the course of a professional medical relationship. Bronson v Sisters of Mercy Health Corp, 175 Mich App 647, 652-653; 438 NW2d 276 (1989); Adkins v Annapolis Hospital, 116 Mich App 558; 323 NW2d 482 (1982). Assuming that negligence in placing incorrect information in a patient's medical chart during hospitalization is "ordinary" negligence so as to excuse the need for expert testimony to establish a breach of the standard of care, the action is not one for ordinary negligence under a three-year statute of limitation. Locke v Pachman, 446 Mich 216, 232-232; 521 NW2d 786 (1994); Thomas v McPherson Community Health Center, 155 Mich App 700, 705-706, 400 NW2d 629 (1986). This Court has previously recognized that the ordinary "nonmedical" negligence involved in mislabeling an x-ray or in entering erroneously the interpretation of an x-ray into a medical chart nonetheless are causes of action in malpractice subject to a two-year statute of limitations. Adkins, supra, at 565; Stitt v Mahaney, 72 Mich App 120, 125; 249 NW2d 319 (1976), rev'd on other grounds, 403 Mich 711 (1978). The negligence in plaintiff's case is indistinguishable from these cases and presents a cause of action for malpractice, and not for ordinary negligence. [Smith v Harper-Grace Hospital, supra, Appx 141a.]

The wisdom of this alternative test turning on the nature of the relationship which gives rise to the duty of care in the first instance can be readily seen in the analogous context of a claim for legal malpractice. Consider a situation where a complaint is filed by an attorney one day after the expiration of the statute of limitations. Whether the immediate cause of the failure to timely file is an error by the attorney in the professional determination of which statute of limitations applies, or an error by a secretary in diarying the filing deadline, all unquestionably would consider the claim in either case to be one for legal malpractice.

This is because the duty to timely file a complaint arises and exists only because of the professional attorney-client relationship. While the issue of whether the ultimate error is one of professional judgment or mere ordinary clerical negligence may determine whether expert testimony is required to establish the specific standard

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of care[2] as a matter of common law, it should not transform the fundamental nature of the claim from that of legal malpractice to ordinary negligence.

Plaintiff's attempt to turn this into a premises liability or products liability action, because of an alleged defective design in the mattress and/or bed frame is without merit. The duty claimed to exist here did not arise and could not exist merely by virtue of the fact that defendant Oak Pointe Villa Nursing Centre is a premises owner. This is obviously not a premises liability action. No mere premises owner would have a duty to evaluate a tenant's subjective medical condition and take appropriate steps to protect the tenant in light of that condition from a condition which was not objectively dangerous to the average person. See Sidorowicz v Chicken Shack, Inc, unpublished opinion per curiam of the Court of Appeals, decided January 17, 2003 (Docket no 239627) (premises owner has no heightened duty to protect blind person from danger on the premises) (Appx 137a), Joyce v Rubin, 249 Mich App 231, 238-239; 642 NW2d 360 (2002) (Because the test to determine an open and obvious danger, is objective, the Court "'look[s] not to whether plaintiff should have known that the [condition] was hazardous, but to whether a reasonable person in his position would foresee the danger.'")

Moreover, pursuant to MCL 333.21731 (Appx 165a), a licensee of a nursing home operated for profit is considered to be the consumer and not the retailer of the tangible personal property purchased or used in the operation of the home, such as

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[2] See Moning v Alfono, 400 Mich 425; 254 NW2d 759 (1977), distinguishing between the general and specific standards of care.

the bed and bed rails at issue here. In Ayyash v Henry Ford Health System, 210 Mich App 142; 533 NW2d 353 (1995), the Court held that in the context of medical care a claim for injury arising out of a health care facility's use of a product in the course of care (there, a medical implant) was a claim premised on a service and a claim for medical malpractice, rather than for product liability.

At issue here ultimately is a service, caring for a patient with needs which are unique and which place the patient at risk for injury without appropriate supervision or monitoring. The duty to provide that service exists only because of the professional heath care provider patient relationship. A claim arising out of the failure to provide that service is a claim for medical malpractice.

D. Alternatively, This Is A Medical Malpractice Action Because Under Common Law It Arises Out Of The Alleged Failure Of A Health Care Facility And Its Employees To Properly Exercise Professional Judgment In Recognizing A Risk Of Positional Asphyxia From A Restraint Due To The Patient's Particular Medical History, And Mental And Physical Condition.

Discovery and the allegations in the first amended complaint in this matter clearly bring it within the "exercise of judgment" common law test for medical malpractice. Discovery established that the risk of injury to plaintiff's decedent from positional asphyxia from bed rail entanglement existed only because of Catherine Hunt's particular medical history, her specific mental and physical condition. Discovery, and common sense, further establish that both the recognition of that risk of positional asphyxiation, and the determination of what appropriately should or could be done to reduce that risk, were dependent on professional judgment.

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(1) **Recognition of the risk of positional asphyxiation from bed rails, which existed as to this particular patient only because of her specific medical history, and the choice of the appropriate steps to reduce that risk, both involve professional judgment.**

As established by the testimony of plaintiff's own expert, the risk of injury posed to this patient by bed rails existed only because of her particular and individual medical and mental disabilities. By the admission of that same expert, the use and monitoring of a restraint, and recognition of the risk of positional asphyxia, clearly is a matter of professional judgment--turning as it does on an analysis of the risk posed by the restraint in light of the patient's particular medical condition.

Dr. Miles emphasized that the risk of entrapment posed by the configuration of the bed and bed rails to Mrs. Hunt was due not merely to the fact that Mrs. Hunt required assistance for activities of daily living, but was the combined result of all aspects of her physical and mental condition:

> Q Okay. When you indicated that she required assistance for activities of daily living, are all persons who require assistance for such activities at risk for entrapment?
>
> A As stated in my previous comment, that the overall profile is one of being frail and disabled and having poor judgment and a history of impulsive behavior and a history of previous entrapments. These are people who are at risk, not the presence of any one of these. [Appx 52a, Miles dep, p 76.]

Dr. Miles indicated that "the central fact is that the woman was in a bed that was unsafe for her given her medical history." (Appx 55a, Miles dep, p 89.) Dr. Miles indicated that precautions should have been taken with regard to the condition of her bed "as part of an individualized treatment plan":

> Q When, in your opinion, should somebody have realized that the bed was unsafe for her?

A Given the inadequacy of the nursing home charting on the bed, and on this patient generally, I think it's a little hard to tell. But I would say this: The patient had a long history of slide fall-type injuries and her environment should have been adjusted as part of the individualized treatment plan for this.

And, furthermore, the facility had a general obligation to all of its patients, including Mrs. Hunt, to provide beds that did not prevent--present a space that was large enough for an entrapment asphyxiation. And they should have been particularly aggressive in using that type of equipment for Mrs. Hunt. [Appx 55a, Miles dep, p 89.]

The record below further established that this risk of asphyxiation injury by entanglement, particularly at the time of the injury here, was not apparent to lay persons, and in fact, was being "missed" even by health care professionals. Mrs. Hunt's attending physician and the state investigator both have testified they were not aware of a risk of asphyxiation to nursing home residents posed by side rails (Appx 43a, dep of investigator Grace Andrews, R.N., p 121, Appx 37a, dep of Donald Dreyfuss, D.O., pp 8-9).

In a 1997 article co-authored by plaintiff's expert, Steven H. Miles, M.D., entitled "Deaths Caused by Bed Rails" (Appx 61a), it was declared that deaths from bed rails at the time of the incident in question here was "under recognized" and not adequately reported on:

Deaths from bed rails are under recognized and preventable clinical events that can occur in any medical setting.

* * *

The risks or benefits of bed rails have not been studied extensively.

* * *

Overall bed rails are used so commonly and seen as so benign that they are used without consent or a clear sense of their role in a treatment plan and without regulatory attention to their design.

* * *

> Deaths caused by bed rails have not been discussed in the general medical literature.
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> * * *
>
> It may be that the lack of clinical education about bed hazards contributes to under recognizing these events. [Appx 61a-62a, J Am Geriatr SOC, July 1997-Vol 45 No 7, "Deaths Caused by Bed Rails", by Cara Parker and Steven H. Miles.]

Thus, by the admission of plaintiff's own expert, professional judgment is required to both recognize and address the risk of positional asphyxia posed by bed rails to a patient in light of that patient's particular mental and physical condition.

The risk here was not posed by an ordinary mattress; it was posed by the restraint (the bed rails) in combination with the mattress. The risk existed only because of this patient's medical condition which was the reason for the patient's admission to this skilled nursing facility. The duty to recognize the risk existed only because this was a skilled nursing health care facility, whose patients were being cared for under the direction of nurses and physicians. The recognition of the risk, and choice of the appropriate method by which to reduce that risk (remove bed rail, add wedge, etc.) were questions beyond the knowledge of lay persons.

(2) The Court of Appeals has previously held that a claim based on the failure to properly use restraints in a health care facility involves professional judgment and is a claim for malpractice.

The "professional judgment" test acknowledged by the Court in Dorris, supra, has been applied by the Court of Appeals to hold on several occasions that an allegation of improper use and monitoring of restraints is a claim for medical malpractice. In Starr v Providence Hospital, 109 Mich App 762; 312 NW2d 152 (1981), the Court of Appeals held that allegations of negligence involving the supervision necessary in a post-operative special care unit of a hospital and the type

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of restraints that should have been used on the elderly patient are "issues involving professional judgments which are beyond the common knowledge and experience of the layman to judge," requiring expert testimony. The Court reasoned:

> The type of restraints to be employed and the use thereof also involves professional judgment. As noted during the trial, several different types of restraints are available, some of which are so severe that they may be used only when authorized by a physician. In addition, the physical condition of a patient to be restrained must also be taken into consideration. Where the restrained patient is ill, as in this case, the use of an improper restraint could be detrimental to his health. [Starr, 766.]

In Waatti v Marquette Hospital, 122 Mich App 44, 49; 329 NW2d 526 (1982), the plaintiff experienced a seizure while sitting on the side of a hospital bed and fractured his arm against the bed rail. Plaintiff's claimed that expert testimony was not required because only issues of ordinary negligence were presented, inasmuch as leaving a seizure patient unattended with the hospital's bed rails down is so obviously negligent as to present issues cognizable by an ordinary layperson. The Court declared:

> We disagree. Whether a seizure patient requires constant medical attendance or restraints is a question of medical management to be established by expert testimony. [Waatti, 49.]

3. The Court of Appeals' majority's conclusion here that this is a claim for ordinary negligence because it involves mere "custodial care" within the knowledge of any lay person is erroneous.

The Court of Appeals' majority's assertion that the "safety of the environment alleged in this case is certainly within the common knowledge and experience of a jury" is contrary to both common sense and the record. The testimony and writings of plaintiff's expert established that the "environment" at issue was not unsafe for the average adult. It was unsafe only for this particular patient because of this particular

patient's history of behavior and mental deficits and physical frailty due to disease, and only because of the use of a physician-ordered restraint (bed rails). The record also established that this was a risk of injury which was at the time of the incident not sufficiently recognized by health professionals, let alone by lay persons. Both the recognition of the risk of positional asphyxia posed by bed rails, and the decision of what to do about that risk, involve professional judgment.

The Court of Appeals' majority's position would necessarily require the conclusion that had anyone observed plaintiff's decedent or the bed in which she lay, such as a family member, a cafeteria worker, or a maintenance worker, they would or should have both recognized the potential risk of injury from positional asphyxia to this particular patient, and known what action to take upon recognition of that risk (remove the bed rails, insert a wedge, etc.). As is amply demonstrated by the deposition of plaintiff's own expert, however, this is obviously not the case.

The average man or woman on the street could not be expected to recognize a risk of serious injury posed by a bed rail and gap between it and a mattress to an adult patient because of the patient's particular mental and physical condition, nor what steps should be taken to alleviate that risk, while still protecting the patient. The average lay person could not be expected to recognize that a bed rail would pose a risk of asphyxiation in combination with the fit or shape of a mattress, or know what to do about it. For the Court of Appeals to characterize this as an environmental question, or one within the understanding of all laypersons, is simply disingenuous and in disregard of the record.

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The distinction the Court of Appeals majority makes between "custodial shelter care" and "medical treatment" in reliance on Owens v Manor Health Care Corp, 159

Ill App 3d 684; 512 NE2d 820 (1987), is clearly erroneous. It has no basis in Michigan common law or statutes. This distinction was made by the Illinois Court of Appeals based on statutory construction of that state's medical malpractice tort reform legislation which applied only to "healing art malpractice." Because the patient there was not being "healed" or restored, but rather "maintained" in a nursing home, the Illinois Court held that act inapplicable.

The Michigan malpractice tort reform statutes allow for no such distinction between "healing" and "custodial shelter care." Further, this was a skilled nursing facility, with respect to which the Legislature specifically has declared that "nursing care" and "medical care" "shall consist of services given to individuals who are subject to prolonged suffering from illness or injury or who are recovering from illness or injury." MCL 333.21715(2). See also MCL 600.5838a, in which the Legislature has effectively extended the definition of medical malpractice to include the conduct of "an employee or agent of a licensed health care facility or agency who is engaging in or otherwise assisting in medical care and treatment." Michigan law does not permit a distinction between "healing" and "maintenance" medical or nursing care.

In Judd v Heartland Health Care Center--Georgian East, unpublished decision of the Federal District Court for the Eastern District of Michigan, docket no 01-CV-73837, rel'd 12/21/01 (Appx 132a), the Court applied Dorris to hold that allegations against a nursing home of negligence of inadequate staffing which allowed plaintiff to lie in her urine, resulting in infection, was a claim for medical malpractice. The judge in Judd, who was also the author of the decision of McLeod v Plymouth Court Nursing Home, 957 F Supp 113 (ED Mich, 1997) (cited with approval by this Court in Dorris), reasoned:

> The case at bar can readily be distinguished from McLeod. First, unlike McLeod, this case does not involve a claim by a patient who has fallen in a hospital or health facility. Second, Plaintiff has not simply alleged that Defendant breached "its duty of reasonable care" in this action. To the contrary, in this case the Plaintiff alleges in her complaint that Defendant breached its duty to adequately staff their facility, and to respond in a reasonable manner when notified by the Plaintiff that she had urinary needs. Finally, unlike McLeod, the facts alleged in Plaintiff's complaint do not present "issues within the common knowledge and experience of the jury." Rather, "allegations concerning staffing decisions and patient monitoring involve questions of professional medical management and not issues of ordinary negligence that can be judged by the common knowledge and experience of a jury." Dorris v. Detroit Osteopathic Hosp, 460 Mich 26, 47; 594 NW2d 445 (1999).

Bed rails are a restraint; requiring as they do a physician's order for administration, bed rails clearly are part of medical treatment or care. Plaintiff's claim turns on a failure to monitor the use of that restraint in terms of recognizing or acting to prevent a risk of injury from use of the bed rails--positional asphyxia--which arose only because of the patient's particular mental and physical condition. This is a claim for malpractice under the "exercise of professional judgment" analysis.

CONCLUSION AND RELIEF REQUESTED

Accordingly, this is a medical malpractice action to which the tort reform requirements apply under any test recognized by the Michigan Legislature or the common law of this state. Defendant Oakpointe Villa Nursing Centre respectfully requests that this Court reverse in part that part of the Court of Appeals' opinion holding that plaintiff has a viable claim for ordinary negligence, and affirm the dismissal of the ordinary negligence suit (Docket No. 98-810412-NO) in its entirety for failure to comply with the tort reform requirements of a notice of intent and affidavit of merit. Defendant further requests that the Court leave intact that part of the Court of Appeals' judgment directing dismissal of the medical malpractice lawsuit as barred by the statute of limitations.

Respectfully submitted,

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